REQUEST FOR SUBMITTER ID NUMBER AND INFORMATION SHEET

(Note: To submit claims electronically you will need a Submitter ID number assigned to your regular billing Provider Number)	EDI SUBMITTER NUMBER
PROVIDER'S NAME	MEDICAID PROVIDER NUMBER
PROVIDER'S ADDRESS CITY STATE ZIP CODE	
PROVIDER'S TELEPHONE NUMBER	PROVIDER'S CONTACT NAME(S)

Billing Intermediary

Complete this section <u>if you have chosen a third party intermediary to submit Medicaid claims for you.</u> (Note: If this option is selected, the "Power of Attorney" form must also be completed and notarized.)

INTERMEDIARY'S NAME	INTERMEDIARY'S SUBMITTER ID NUMBER
INTERMEDIARY'S ADDRESS CITY STATE ZIP CODE	
INTERMEDIARY'S TELEPHONE NUMBER	INTERMEDIARY'S CONTACT NAME(S)

DSHS 18-622 (REV. 04/2004)

Send to: Provider Enrollment
PO Box 45562
Olympia WA 98504-5562
1-866-545-0544